# CONGRESSIONAL BUDGET OFFICE
# PRELIMINARY COST ESTIMATE

★July 24, 1998

# H.R. 4250
## Patient Protection Act of 1998

*With proposed amendment*

**SUMMARY**

The Patient Protection Act of 1998 would give members of group health plans rights to obtain certain services, establish new grievance procedures for members of group health plans under the Employee Retirement Income Security Act (ERISA), limit legal actions for health care liability, allow for the creation of association health plans (AHPs) and HealthMarts, expand the availability of medical savings accounts (MSAs), protect the confidentiality of health information, and allow community health organizations to offer health insurance coverage. The bill would affect the costs of private insurance as well as the federal budget, and estimates of its effects are subject to more than the usual amount of uncertainty. In addition, because of the limited time available to review the bill and the proposed amendment, this estimate is preliminary and subject to revision.

The bill would affect the federal budget in several ways. First, expanding the availability of tax-favored medical savings accounts would reduce federal receipts from income and payroll taxes. Second, the proposed patient protections, grievance procedures, and medical liability reforms would together tend to reduce premiums for employer-sponsored health insurance, substitute taxable wages for nontaxable fringe benefits, and slightly increase revenues. Third, the bill would require additional spending for federal administrative and regulatory activities, subject to appropriation of the necessary amounts. Fourth, the bill contains changes in tax laws designed to offset the net costs of the other provisions.

By preempting or superseding state laws governing the regulation of health care, the bill would create several intragovernmental mandates as defined in the Unfunded Mandates Reform Act (UMRA), but their cost would fall below the threshold established in UMRA ($50 million in 1996, adjusted annually for inflation). Several provisions of the bill, including the patient protections and grievance procedures, would impose private-sector mandates as defined in UMRA. CBO estimates that the direct costs of those mandates would

greatly exceed the threshold established in UMRA ($100 million in 1996, adjusted annually for inflation) every year after 1999.

## ESTIMATED COST TO THE FEDERAL GOVERNMENT

The estimated budgetary impact of the bill is shown in the following table. The costs of this legislation fall within budget functions 550 (health) and 570 (Medicare).

## BASIS OF ESTIMATE

The proposed patient protections, informational requirements, grievance procedures, and medical liability reforms would affect the federal budget through their effect on premiums for employer-sponsored health insurance. CBO estimates that, taken together, these provisions would be likely to reduce average premiums by about 0.1 percent, although their combined effect could be a small increase in premiums or a larger decrease. The estimate assumes that about 60 percent of the decrease in premiums would be offset through changes in fringe benefits and that about 40 percent would be passed on to employees as higher wages. The medical liability reforms would also reduce spending for Medicare and Medicaid. The expansion of medical savings accounts and the revenue offsets would change federal tax laws; their effects were estimated by the Joint Committee on Taxation.

### Patient Protections and Grievance Procedures

CBO estimates that the patient protection provisons, informational requirements, and new grievance procedures under ERISA would eventually increase premiums for a typical employer-sponsored health plan by 0.2 percent to 0.4 percent.

**Patient Protections**. The bill would require that plans pay for hospital emergency visits that meet a prudent layperson standard, permit direct access to an obstetrical and gynecological specialist for covered routine care, allow participants to choose pediatricians as primary care physicians for children under 18 years of age, and prohibit health plans from interfering with medical communications between physicians and their patients.

The prudent layperson standard for emergency room services would increase plan premiums in two ways. First, plans could not deny services that would be viewed as medically necessary by a reasonable layperson at the time he or she sought care. Second, such services could not be denied or paid at a lower rate because they were provided by nonparticipating providers, although the provision would limit a plan's responsibility for payment to those

Preliminary Estimate of Budgetary Effects of H.R. 4250, The Patient Protection Act, as modified by sponsors

| | By fiscal year, in billions of dollars | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | 1998 | 1999 | 2000 | 2001 | 2002 | 2003 | 2004 | 2005 | 2006 | 2007 | 2008 |
| **Revenues** | | | | | | | | | | | |
| Expand Medical Savings Accounts[a] | 0 | -0.1 | -0.2 | -0.3 | -0.3 | -0.4 | -0.4 | -0.5 | -0.5 | -0.6 | -0.6 |
| Income and HI Payroll Taxes[a] | 0 | 0 | b | b | b | b | b | b | b | b | b |
| Revenue Offsets[a] | 0.6 | 1.2 | 0.4 | -0.4 | -0.8 | -1.1 | -1.2 | 0.9 | 1.3 | 1.2 | N/A |
| Subtotal, On-Budget | 0.6 | 1.1 | 0.2 | -0.7 | -1.1 | -1.4 | -1.6 | 0.5 | 0.8 | 0.7 | N/A |
| Social Security Payroll Taxes[a] | 0 | 0 | b | b | b | b | b | b | b | b | b |
| Total | 0.6 | 1.1 | 0.2 | -0.7 | -1.1 | -1.4 | -1.6 | 0.4 | 0.8 | 0.7 | N/A |
| **Direct Spending** | | | | | | | | | | | |
| Effect of Liability Provisions on Medicare and Medicaid Spending | 0 | 0 | b | -0.1 | -0.1 | -0.1 | -0.2 | -0.2 | -0.2 | -0.2 | -0.2 |
| Total | 0 | 0 | b | -0.1 | -0.1 | -0.1 | -0.2 | -0.2 | -0.2 | -0.2 | -0.2 |

NOTE: N/A = not available.
Numbers may not add to totals because of rounding.

a. From the Joint Committee on Taxation.
b. Costs or savings of less than $50 million.

emergency services needed to screen and stabilize the patient. The other patient protection provisions would increase costs only slightly.

**Patient Access to Information**. The bill would require health plans periodically to provide certain information to enrollees and to make available on request other kinds of information to both enrollees and prospective enrollees. Most of the required information is typically provided now as part of a plan's handbook or could easily be incorporated into that document. Although many plan documents would have to be amended to meet the requirements of this provision, such documents are continually changed to reflect new terms. The bill would require participating physicians and hospitals to have credentialing information available to patients, but it would not require health plans to compile and update such information. Plans would be responsible for making available to participants any quality or plan performance data they collect, but they would not be required to collect such data. In addition, plans with drug formularies would be required to make reasonable attempts to keep participants informed (through vehicles such as web pages or articles in employee newsletters) of any formulary changes. Taken together, these requirements would require some plans to incur additional administrative costs to update data sources and monitor compliance.

**Grievance Procedures**. The bill would require group health plans under ERISA to conform to new procedures and time limits for making and reviewing decisions on medical necessity, coverage, and access to specialists. It would require plans to inform patients of their right to review and reconsideration of adverse initial decisions and would require plans to meet timeliness requirements depending on the urgent or emergency nature of the medical problem. The clock would start running when the reviewing physician received information sufficient to make a decision. For decisions regarding medical necessity and experimental treatments, patients would be able to obtain another review by an independent external expert, but they would have to pay a fee of $25 to $100 to the plan if they exercised this right. The plan would not be obliged to accept the recommendation of the external expert, but if the patient successfully challenged the plan's final decision in federal court, the plan could be assessed civil penalties of up to $500 per day or $250,000 in total. Plans would be required to pay reasonable fees to plaintiffs' attorneys when they represent a successful claimant in a judicial proceeding.

Most plans already have an internal appeals process, but they operate with more flexibility on timing than they would have under this provision. Consequently, some plans would have to add more review personnel to meet the specified time limits. Costs would also increase because of the requirement for external review. Several aspects of the bill (such as limiting the types of plan decisions that could be appealed and requiring claimants to pay a fee) would limit the frequency of external appeals. However, adding civil penalties and payment of attorneys' fees to the potential rewards from bringing action in federal court would encourage participants to seek external review, because those remedies would be available

only if a plan had rejected the recomendation of an external reviewer. Thus, plans would be likely to consider the potential for litigation when they considered the recommendations of external experts.

**Health Care Liability**

The bill would establish uniform standards for all health care liability actions brought in any state or federal court, except for actions under ERISA and vaccine-related injury cases. The standards would apply to all medical malpractice cases and actions against manufacturers of pharmaceuticals and medical devices. Federal law would preempt inconsistent state laws, unless they give defendants more rights than would exist under these provisions. Provisions include a $250,000 cap on noneconomic damages (that is, pain and suffering), a separate $250,000 cap on punitive damages, mandated periodic payment of future losses when they exceed $50,000, defendant's right to admit evidence of collateral source payments, limitation on joint and several liability, and restrictions on statutes of limitations. The bill would also prohibit punitive damages altogether for drugs and devices approved by Food and Drug Administration (FDA) unless the manufacturer was found to intentionally withhold or misrepresent material information to the FDA.

Several studies suggest that tort reforms of the kind included in this bill substantially reduce medical liability premiums as well as malpractice claims and payments and premiums for medical liability insurance. Similar provisions are already in effect in many states. In 1993, 65 percent of the U.S. population lived in states with collateral source offset provisions, and 45 percent of the population lived in states with caps on noneconomic damages. Those two provisions in particular have been found extremely effective in reducing the amount of claims paid and medical liability premiums. Reductions in the threat of malpractice suits and lower malpractice premiums may also affect the practice of defensive medicine by physicians and other providers, although this effect is likely to be small compared with the effect on malpractice premiums. CBO estimates that the medical liability tort reforms included in this subtitle would ultimately reduce private health plan premiums by 0.3 percent to 0.5 percent.

Lower medical malpractice costs would contribute to slower growth in Medicare spending, because changes in malpractice premiums are used to calculate the measures of inflation used to update payment rates for hospitals, physicians, and other providers. Medicaid spending would also be reduced as states adjust payment rates to reflect lower costs of providers for liability insurance. CBO estimates that these changes in medical liability would reduce federal direct spending for Medicare and Medicaid by about $0.3 billion over the 1999-2003 period and by $1.5 billion over ten years.

**Association Health Plans and HealthMarts**

Several provisions of the bill would affect the market for health insurance for small employers. The bill would permit the formation of HealthMarts—non-profit entities that would offer health insurance products to the employees of small firms. A HealthMart would have to offer coverage to employees of all small firms within the Mart's geographic area that were willing to enter an exclusive contract with the Mart for employee insurance. The health insurance products offered through a HealthMart would be fully insured products offered by state-licensed issuers. In contrast to policies sold in the current small-group insurance market, a Mart's products would not have to comply with state benefit mandates (except for state mandates to cover a specific disease). Like products in the current small-group market, products offered through a Mart would be subject to state premium taxes and assessments to fund high-risk pools.

The bill would also allow organizations such as trade, industry, and professional associations and chambers of commerce to sponsor association health plans for their members and affiliated members. AHPs could obtain federal certification for these health plans, which would be exempt from state-mandated benefits, except for coverage of specific diseases. However, AHPs would be subject to state regulation of premiums for small-employer-group markets, except that the AHP itself would comprise the market. For example, if a state requires community rating in its small-group health insurance market, the participating employer groups in the AHP would have to be community-rated among themselves, but those community rates would not necessarily bear any relation to rates offered to small employers outside the AHP. This feature would limit, though not eliminate, the ability of AHPs to enroll healthier people and thereby increase premiums in the small-group insurance market.

The AHP and HealthMart provisions could affect federal revenues because changes in employer payments for employee health insurance would result in offsetting changes in taxable employee compensation. The direction of that effect is uncertain, however, and the estimate assumes that the effect would be small. If the provisions resulted in greater spending by employers on employee health insurance, then federal revenues would fall as firms substituted non-taxable insurance benefits for taxable earnings. That scenario is more likely if the new products encourage substantial increases in the number of small firm employees who have insurance. Such a response could occur if lower-priced insurance products without state-mandated benefits were sufficiently appealing to otherwise uninsured employees. In contrast, federal revenues would increase if total employer spending on insurance fell. That scenario would be more likely if reduced-price policies, which omitted mandated benefits, were purchased primarily for those who would have been insured anyway rather than for otherwise uninsured employees. In either case, permitting offerings without mandated benefits would lower the price of the average policy while increasing the variance in premiums among small firms. That variance would be amplified to the extent that policies

without mandated benefits were relatively appealing to healthier risks but would be limited if those policies did not become popular. The variance in premiums could also rise if AHPs or HealthMarts tended to enroll firms with healthier employees. Association health plans would also be subject to a one-time certification fee of $5,000 and (for self-insured plans) an annual solvency fee of $5,000.

**Medical Savings Accounts**

The bill would amend the provisions of the Internal Revenue Code governing medical savings accounts to increase the amount of wages, benefits, and investment income given favorable tax treatment and to make these accounts more widely available. Under current law, contributions to an MSA by individuals covered by high-deductible health insurance plans are deductible, and contributions by employers on behalf of the covered individual are excludable for income and payroll tax purposes. Investment earnings of MSAs are excluded from taxable income in the year earned, and withdrawals from MSAs for medical expenses are tax-free.

The bill would reduce the minimum annual deductible for a high-deductible health insurance policy from $1,500 to $1,000 for an individual policy and from $3,000 to $2,000 for a family policy; these amounts are indexed for inflation. Currently, the amount of the tax deduction allowed for contributions to MSAs is limited to between 60 percent and 75 percent of the annual deductible. The bill would increase this deduction to the full amount of the annual deductible. The bill would remove the limit on the number of MSAs and would allow MSAs to be offered by small employers and as part of a cafeteria plan. The Joint Committee on Taxation estimates that these changes would reduce income and payroll tax revenues by $1.3 billion over the 1999-2003 period.

**Confidentiality of Health Information**

The bill would require health care providers, health plans, employers, health or life insurers, and educational institutions to provide a patient with access to his or her records, allow the patient to request amendments, and implement safeguards to protect individually identifiable health information. These requirements would impose minor administrative costs on the affected entities, most of which could be passed on to the requestor of the information through fees. The provisions requiring the implementation of safeguards and allowing the disclosure of information for health care operations could reduce costs slightly for affected entities that operate in states with stricter laws.

**Revenue Offsets**

The bill contains several changes in tax laws designed to offset the net cost of the other provisions. The Joint Committee on Taxation has estimated the effects of these provisions.

**Community Health Organizations**

The bill would allow community health organizations (CHOs), in certain circumstances, to obtain a waiver of state licensure requirements for offering health insurance coverage. CHOs could obtain such waivers for up to 36 months (renewable for a further 36 months) if states failed to act on a CHO's application for licensure within 90 days, used different standards than those applied to other organizations in order to deny the application, or denied the application using solvency standards that were tougher than those established by HHS. The only federal costs for these provisions would be discretionary expenditures by HHS, which would have to establish solvency standards, develop a certification process, and continue to monitor any CHOs that obtained certification.

**Federal Administrative Costs**

The bill would require additional spending for administration and regulatory activities, subject to appropriation of the necessary amounts. The Departments of Labor (DoL), Health and Human Services (HHS) and Treasury would share the responsibility for ensuring that group health plans met the new standards for patient protection and access to information.

DoL would also be required to ensure that ERISA plans complied with the standards for grievance procedures, and would face new costs for regulating association health plans. The agency could delegate the certification and regulation of AHPs to states if they agreed, but states would probably be unwilling to assume that responsibility without federal funding.

HHS would be responsible for developing solvency standards for community health organizations (CHOs) that wished to become risk-bearing health plans, and certifying and regulating those CHOs that sought federal waivers from state regulation. The agency would also be required to regulate HealthMarts, and the bill establishes a new division within HHS to carry out that function.

**PAY-AS-YOU-GO CONSIDERATIONS**

Section 252 of the Balanced Budget and Emergency Deficit Control Act sets up pay-as-you-go procedures for legislation affecting direct spending or receipts. Estimates of the net

changes in outlays and governmental receipts that are subject to pay-as-you-go procedures are not yet available.

## ESTIMATED IMPACT ON STATE, LOCAL, AND TRIBAL GOVERNMENTS

A number of provisions in the bill would preempt or supersede state law governing the regulation of health care. These preemptions would be intergovernmental mandates as defined in the Unfunded Mandates Reform Act (UMRA); however, the budgetary impact on state, local, or tribal governments of these mandates would not result in costs exceeding the threshold established in UMRA ($50 million, adjusted annually for inflation).

With some exceptions, the bill would prevent states from limiting the ability of association health plans to determine the specific items and services to be included in a medical care plan. Also, state laws that impede the development of HealthMarts or that govern benefit coverage requirements would be preempted. While these preemptions of state authority would be intergovernmental mandates, the budgetary impacts associated with such preemptions would be minimal because states may realize decreased regulatory responsibility.

In addition, state taxing authority would be preserved or in some cases expanded. New association health plans that offer health benefits that are not fully insured would be subject to taxes on premiums or contributions, with some adjustments. Any potential increase in state tax receipts would depend upon the underlying market changes precipitated by the bill. At this time, CBO is unable to determine the net effect of such changes.

The bill would also allow the Secretary of Health and Human Services to waive state licensure requirements in some cases. Under the bill, community health organizations (CHO) would be able to offer health insurance coverage. If a CHO submits an application to a state to offer such coverage and the state fails to act upon the application within 90 days, the secretary could waive the licensure requirement. The licensure requirement also could be waived if the application is denied on the basis of state standards that are not generally applicable to other products. Similar waiver provisions would apply to health benefit coverage provided through Health Marts. This waiver authority would place no new responsibilities on state governments; consequently, there would be no budgetary impact.

Finally, the bill would place a number of patient protection requirements on group health care plans. However, state, local, and tribal governments would be able to opt out of those requirements under the Public Health Service Act. Consequently, those requirements would not be intergovernmental mandates as defined by UMRA, and they would affect the budgets of state, local, or tribal governments only if they chose to comply with them.

## ESTIMATED IMPACT ON THE PRIVATE SECTOR

The bill would impose several private-sector mandates as defined in UMRA. They include the patient protection provisions, requirements to grant patients access to their medical records, and requirements for plans to establish appeals procedures for handling patients' grievances. CBO estimates that the direct costs of those mandates to private-sector entities would significantly exceed the threshold specified in UMRA ($100 million in 1996, adjusted annually for inflation) every year after 1999.

## ESTIMATE PREPARED BY:

Federal Cost Estimate: James Baumgardner, Linda Bilheimer, Tom Bradley, Stuart Hagen, Judith Wagner, and Amy Weber

Impact on State, Local and Tribal Governments: Leo Lex

Impact on the Private Sector: Judith Wagner and Kathryn Rarick

## ESTIMATE APPROVED BY:

Paul N. Van de Water
Assistant Director for Budget Analysis